F. The settle-up property-related payment rate for a nursing facility which commenced construction after June 30, 1985, shall be established as follows:

(1) The appraised value determined in item D, subitem (1) must be updated in accordance with Section 16.020, item B prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(2) The nursing facility's allowable debt, allowable interest rate, and allowable interest expense for the interim rate period shall be computed in accordance with Sections 16.050, 16.060, and 16.070.

(3) The settle-up building capital allowance shall be determined in accordance with Section 16.080 or 16.090.

(4) The equipment allowance shall be updated in accordance with Section 16.100 prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(5) The settle-up property-related payment rate must be the sum of subitems (3) and (4).

(6) Resident days may be used instead of 95% percent capacity days.

G. The property-related payment rate for the nine months following the settle-up for a nursing facility which commenced construction after June 30, 1985, shall be established in accordance with item F except that 95% percent capacity days must be used.

H. The property-related payment rate for the rate year beginning July 1 following the nine-month period in item G must be determined under this section.

I. A newly-constructed nursing facility or one with a capacity increase of 50 percent or more must continue to receive the interim property-related payment rate until the settle-up property-related payment rate is determined under this section.

J. The interim real estate taxes and special assessments payment rate shall be established using the projected real estate taxes and special assessments cost divided by anticipated resident days. The settle-up real estate taxes and special assessments payment rate

shall be established using the real estate taxes and special assessments divided by resident days. The real estate and special assessments payment rate for the nine months following the settle-up shall be equal to the settle-up real estate taxes and special assessments payment rate.

SECTION 17.000 PAYMENT FOR REAL ESTATE TAXES AND SPECIAL ASSESSMENTS

The total real estate taxes and actual special assessments and payments permitted under Section 5.000, item CC must be divided by actual resident days to compute the payment rate for real estate taxes and special assessments. Special assessments are reimbursed as paid by the facility except that facilities that incur special sewer assessments as part of their utility bill may reclassify that amount to the real estate tax and special assessment cost category. Real estate taxes are reimbursed based on the real estate tax assessed for the calendar year following the reporting year and are adjusted to account for the difference between the tax year and the reporting year in which the taxes are due. This adjustment is equivalent to ½ the increase or decrease in the property tax liability of a facility. The Commissioner shall include the reported actual or payments in lieu of real estate taxes of each nursing facility as an operating cost of that nursing facility. Allowable costs under this subdivision for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount that a nursing facility would have paid to a city or township and county for fire, police, sanitation an road maintenance costs had real estate taxes been levied on that property for those purposes.

SECTION 17.010 **Payment for preadmission screening fees.** The estimated annual cost of screenings for each nursing facility are included as an allowable operating cost for reimbursement purposes. The estimated annual costs reported are divided by the facility's actual resident days for the cost report period. The resulting per diem amount is included in the calculation of the total payment rate under Section 18.000. However, these costs are not included in the calculation of either the care related or other operating cost limits, nor are they indexed to account for anticipated inflation.

SECTION 17.020 **Payment for increase in Department of Health license fees.** A nursing facility's case mix payment rates include an adjustment to include the cost of any increase in Minnesota Department of Health licensing fees for the facility taking effect on or after July 1, 2001.

SECTION 18.000 COMPUTATION OF TOTAL PAYMENT RATE

SECTION 18.010 **Total payment rate.** The total payment rate is the sum of the operating cost payment rate (including any efficiency incentive calculated under Sections 11.030 and 11.040, and the preadmission screening cost per diem calculated under Section 17.010), the property-related payment rate, and the real estate tax and special assessments payment rate. The total payment rate becomes effective on July 1 of the rate year following the reporting year.

SECTION 18.020 **Private payment rate limitation.** The total payment rate must not exceed the rate paid by private paying residents for similar services for the same period. The private payment rate limitation shall not apply to retroactive adjustments to the total payment rate unless the total payment rate being adjusted was subject to the private payment rate limitation.

SECTION 18.030 **Private room payment rate.** A private room payment rate of 115 percent of the established total payment rate for a resident must be allowed if the resident is a medical assistance recipient and the private room is considered as a medical necessity for the resident or others who are affected by the resident's condition except as in Section 16.110, item C. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the department for approval or denial by the Department on the basis of medical necessity.

SECTION 18.040 **Adjustment of total payment rate.** If the Department finds nonallowable costs, errors, or omissions in the nursing facility's historical costs, the nursing facility's affected total payment rates must be adjusted. If the adjustment results in an underpayment to the nursing facility, the Department shall pay to the nursing facility the underpayment amount within 120 days of written notification to the nursing facility. If the adjustment results in an overpayment to the nursing facility, the nursing facility shall pay to the Department the entire overpayment within 120 days of receiving the written notification from the Department. Interest charges must be assessed on underpayment or overpayment balances outstanding after 120 days written notification of the total payment rate determination.

If an appeal has been filed under Section 19.000, any payments owed by the nursing facility or by the Department must be made within 120 days of written notification to the nursing facility of the Department's ruling on the appeal. Interest charges must be assessed on balances outstanding after 120 days of written notification of the Department's ruling on the appeal. The annual interest rate charged must be the rate charged by the Commissioner of the

department of revenue for late payment of taxes, which is in effect on the 121st day after the written notification.

SECTION 19.000 APPEAL PROCEDURES

SECTION 19.010 **Scope.** A provider may appeal from a determination of a payment rate established pursuant to this attachment and reimbursement rules of the Department if the appeal, if successful, would result in a change to the provider's payment rate or to the calculation of maximum charges to therapy vendors under Section 22.130. Appeals must be filed in accordance with procedures in this section.

SECTION 19.020 **Filing an appeal.** To appeal, the provider will file with the Department a written notice of appeal; the appeal must be postmarked or received by the Commissioner within 60 days of the date the determination of the payment rate was mailed or personally received by a provider, whichever is earlier. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the Commissioner.

SECTION 19.030 **Contested case procedures appeals review process.** Effective August 1, 1997, the following apply.

A. Effective for desk audit appeals for rate years beginning on or after July 1, 1997, and for field audit appeals filed on or after that date, the Commissioner shall review appeals and issue a written appeal determination on each appeals item within one year of the due date of the appeal. Upon mutual agreement, the Commissioner and the provider may extend the time for issuing a determination for a specified period. The Commissioner shall notify the provider by first class mail of the appeal determination. The appeal determination takes effect 30 days following the date of issuance specified in the determination.

B. In reviewing the appeal, the Commissioner may request additional written or oral information from the provider. The provider has the right to present information by telephone, in writing, or in person concerning the appeal to the Commissioner prior to the

issuance of the appeal determination within six months of the date the appeal was received by the Commissioner. Written requests for conferences must be submitted separately from the appeal letter. Statements made during the review process are not admissible in a contested case hearing absent an express stipulation by the parties to the contested case.

C. For an appeal item on which the provider disagrees with the appeal determination, the provider may file with the Commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the Commissioner within 30 days of the date of issuance specified in the determination. A contested case demand for an appeal item nullifies the written appeal determination issued by the Commissioner for that appeal item. The Commissioner shall refer any contested case demand to the Office of the Attorney General.

D. A contested case hearing must be heard by an administrative law judge. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the determination of a payment rate is incorrect.

E. Regardless of any rate appeal, the rate established must be the rate paid and must remain in effect until final resolution of the appeal or subsequent desk or field audit adjustment.

F. The Commissioner has discretion to issue to the provider a proposed resolution for specified appeal items upon a request from the provider filed separately from the notice of appeal. The proposed resolution is final upon written acceptance by the provider within 30 days of the date the proposed resolution was mailed to or personally received by the provider, whichever is earlier.

G. Effective August 1, 1997, the Commissioner may use the procedures described in this section to resolve appeals filed before July 1,1997.

SECTION 19.040 **Attorney's fees and costs.**

A. For an issue appealed under Section 19.010, the prevailing party in a contested case proceeding or, if appealed, in subsequent judicial review, must be awarded reasonable attorney's fees and costs incurred in litigating the appeal, if the prevailing party shows that the position of the opposing party was not substantially justified. The procedures for awarding fees and costs set forth in state law regarding procedures for award of fees in contested cases

must be followed in determining the prevailing party's fees and costs except as otherwise provided in this section. For purposes of this section, "costs" means subpoena fees and mileage, transcript costs, court reporter fees, witness fees, postage and delivery costs, photocopying and printing costs, amounts charged the Commissioner by the office of administrative hearings, and direct administrative costs of the Department; and "substantially justified" means that a position had a reasonable basis in law and fact, based on the totality of the circumstances prior to and during the contested case proceeding and subsequent review.

B. When an award is made to the Department under this section, attorney fees must be calculated at the cost to the Department. When an award is made to a provider under this section, attorney fees must be calculated at the rate charged to the provider except that attorney fees awarded must be the lesser of the attorney's normal hourly fee or $100 per hour.

C. In contested case proceedings involving more than one issue, the administrative law judge shall determine what portion of each party's attorney fees and costs is related to the issue or issues on which it prevailed and for which it is entitled to an award. In making that determination, the administrative law judge shall consider the amount of time spent on each issue, the precedential value of the issue, the complexity, of the issue, and other factors deemed appropriate by the administrative law judge.

D. When the Department prevails on an issue involving more than one provider, the administrative law judge shall allocate the total amount of any award for attorney fees and costs among the providers. In determining the allocation, the administrative law judge shall consider each provider's monetary interest in the issue and other factors deemed appropriate by the administrative law judge.

E. Attorney fees and costs awarded to the Department for proceedings under this section must not be reported or treated as allowable costs on the provider's cost report.

F. Fees and costs awarded to a provider for proceedings under this section must be reimbursed to them within 120 days of the final decision on the award of attorney fees and costs.

G. If the provider fails to pay the awarded attorney fees and costs within 120 days of the final decision on the award of attorney fees and costs, the Department may collect the amount due through any method available to it for the collection of medical assistance overpayments to providers. Interest charges must be assessed on balances outstanding after

120 days of the final decision on the award of attorney fees and costs. The annual interest rate charged must be the rate charged by the Commissioner of revenue for late payment of taxes that is in effect on the 121st day after the final decision on the award of attorney fees and costs.

H. Amounts collected by the Commissioner pursuant to this section must he deemed to be recoveries.

I. This section applies to all contested case proceedings set on for hearing by the Commissioner on or after April 29, 1988, regardless of the date the appeal was filed.

SECTION 19.050 **Legal and related expenses.** Legal and related expenses for unresolved challenges to decisions by governmental agencies shall be separately identified and explained on the provider's cost report for each year in which the expenses are incurred. When the challenge is resolved in favor of the governmental agency, the provider shall notify the Department of the extent to which its challenge was unsuccessful or the cost report filed for the reporting year in which the challenge was resolved. In addition the provider shall inform the Department of the years in which it claimed legal and related expenses and the amount of the expenses claimed in each year relating to the unsuccessful challenge. The Department shall reduce the provider's medical assistance rate in the subsequent rate year by the total amount claimed by the provider for legal and related expenses incurred in an unsuccessful challenge to a decision by a governmental agency.

SECTION 20.000 SPECIAL EXCEPTIONS TO THE PAYMENT RATE

Section 20.010 **Swing beds.** Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed unless:

A. The facility in which the swing bed is located is eligible as a sole community provider, as defined in 42 CFR §412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute-care beds.

B. Nursing facility care has been recommended for the person by a long-term care consultation team.

C. The person no longer requires acute-care services.

D. No nursing facility beds are available within 25 miles of the facility.

E. Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interest of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility.

The daily medical assistance payment rate for nursing care for a person in a swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually on July 1 of each year.

SECTION 20.020 **Negotiated rates for services for ventilator-dependent persons.** A nursing facility may receive a negotiated payment rate to provide services to a ventilator-dependent person if:

A. Nursing facility care has been recommended for the person by a long-term care consultation team.

B. The person has been hospitalized and no longer requires inpatient acute care hospital services.

C. Necessary services for the person cannot be provided under existing nursing facility rates.

A negotiated adjustment to the operating cost payment rate for a nursing facility must reflect only the additional cost of meeting the specialized care needs of a ventilator-dependent person. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest ~~multiple bedroom rate for a case mix classification K; or, upon implementation of the RUGs-based case mix system, 200 percent of the highest~~ RUGs rate. For persons initially admitted to a facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the highest ~~multiple bedroom rate for a case mix classification K at that facility; or, upon implementation of the RUGS-based case mix system, 300 percent of the highest~~ RUGs rate.

The adjustment may be negotiated with a resident who is ventilator-dependent, for that resident.

SECTION 20.025 **Special payment rates for short-stay nursing facilities.** For the rate year beginning on or after July 1, 1993, a nursing facility whose average length of stay for the preceding reporting years is (1) less than 180 days; or (2) less than 225 days in a nursing facility with more than 315 licensed beds must be reimbursed for allowable costs up to 125 percent of the total care-related limit and 105 percent of the other-operating-cost limit for hospital-attached nursing facilities. A nursing facility that received the benefit of this limit during the rate year beginning July 1, 1992, continues to receive this rate during the rate year beginning July 1, 1993 even if the nursing facility's length of stay is more than 180 days in the rate years subsequent to the rate year beginning July 1, 1991. For purposes of this section a nursing facility shall compute its average length of stay by dividing the nursing facility's actual resident days for the reporting year by the nursing facility's total resident discharges for that reporting year.

SECTION 20.026 **Interim closure payments for nursing facilities designated for closure under an approved closure plan and special rate adjustments for nursing facilities remaining open under an approved closure plan.** Instead of payments pursuant to Sections 1.000 to 21.000 or pursuant to the prospective rate-setting methodology in Section 22.000, the Department may approve a closure plan or a phased plan, permitting certain nursing facilities to receive interim closure payments or special rate adjustments.

A. For the purposes of this section, the following have the meanings given.

(1) "Closure plan" means a system to close one or more nursing facilities and reallocate the resulting savings to provide special rate adjustments at other nursing facilities. A closure plan may be submitted by nursing facilities that are owned or operated by a nonprofit corporation owning or operating more than 22 nursing facilities. Approval of a closure plan expires 18 months after approval, unless commencement of closure has occurred at all nursing facilities designated for closure under the plan.

(2) "Commencement of closure" means the date the Department of Health is notified of a planned closure, as part of an approved closure plan.

(3) "Completion of closure" means the date the final resident of a facility designated for closure in a closure plan is discharged.

(4) "Interim closure payments" means the medical assistance payments that may be made to a nursing facility designated for closure in an approved closure plan.

(5) "Phased plan" means a closure plan affecting more than one nursing facility undergoing closure that is commenced and completed in phases.

(6) "Special rate adjustment" means an increase in a nursing facility's operating rates. The special rate adjustment for each facility will be allocated proportionately to the various rate per diems included in that facility's operating rate.

B. The Department will not approve a closure plan or a phased plan unless it determines that projected state savings equal or exceed projected state and county government costs, including facility costs during the closure period, the estimated costs of special rate adjustments, estimated resident relocation costs, the cost of services to relocated residents, and state agency administrative costs relative to the plan. To achieve cost neutrality, costs may only be offset against savings that occur within the same state fiscal year. For purposes of a phased plan, the requirement that costs must not exceed savings applies to both the aggregate costs and savings of the plan and to each phase of the plan.

C. Interim closure payments. To pay interim closure payments, the Department will:

(1) Apply the interim and settle-up rate provisions of Section 12.000 to include facilities covered under this section, effective from commencement of closure to completion of closure;

(2) Notwithstanding Section 16.140, item B, extend the length of the interim period, but no longer than 12 months;

(3) Limit the amount of payable expenses related to the acquisition of new capital assets;

(4) Prohibit the acquisition of additional capital debt or refinancing of existing capital debt unless prior approval is obtained from the Department;

(5) Establish as the aggregate administrative operating cost limitation for the interim period the actual aggregate administrative operating costs for the period immediately before commencement of closure that is of the same duration as the interim period;